Prisons & Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Alex Verdu Munoz, a prisoner at HMP Manchester, on 15 May 2022

**A report by the Prisons and Probation Ombudsman**

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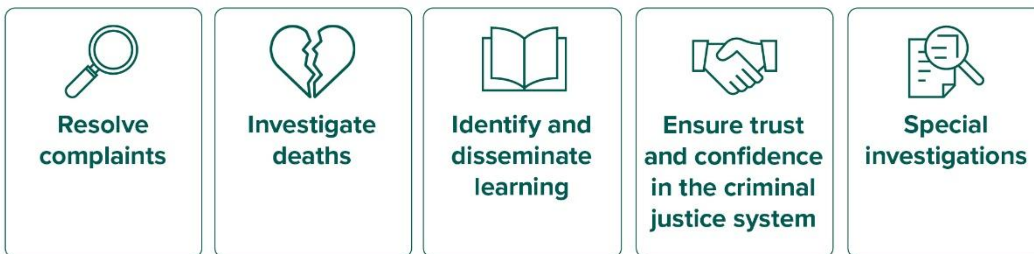
## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO




## WHAT WE VALUE

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Alex Verdu Munoz was found hanged in his cell at HMP Manchester, on 15 May 2022. He was 26 years old. I offer my condolences to Mr Munoz's family and friends. Mr Munoz was the third prisoner to take his own life at Manchester in three years.

Prison staff monitored Mr Munoz under suicide and self-harm prevention procedures (known as ACCT) for much of his time in prison. He told staff that he had received numerous threats from other prisoners, and he isolated himself as a result. The ACCT procedures were generally supportive, and prison staff arranged a move to the healthcare inpatient unit. Mr Munoz received particularly good support from a chaplain at Manchester.

While staff acknowledged Mr Munoz's fear for his safety, and created an isolation plan to support him, there is no evidence that they investigated the threats against him or sought to identify and address the perpetrators. There was also a missed opportunity to provide additional support through the key worker scheme.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Adrian Usher**
**Prisons and Probation Ombudsman** **April 2024**

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# Summary

## Events

1. On 11 March 2022, Mr Alex Verdu Munoz (an Argentinian national) was charged with murder and remanded to HMP Dovegate. He sustained serious leg injuries in a car accident while being chased by police. Due to his offence, staff monitored him under suicide and self-harm prevention procedures (ACCT) while in prison.

2. On 17 March, Mr Munoz was transferred to HMP Manchester. Staff at Manchester kept the ACCT in place as a supportive measure. On 23 March, Mr Munoz reported that he had been threatened by prisoners on the wing due to his offence. In response, staff arranged a separate, isolated, regime for Mr Munoz and, on 14 April, transferred him to the healthcare inpatient unit when a space became available.

3. On 13 May, Mr Munoz attended court as part of the ongoing legal proceedings relating to his murder charge. The next day, a nurse completed a welfare assessment as a precautionary measure following his court appearance. She raised no concerns.

4. At around 9.15am on 15 May, a prisoner who was delivering canteen sheets saw Mr Munoz hanging and shouted for an officer to attend his cell. The officer entered the cell and cut the ligature. He told us that Mr Munoz showed no signs of life.

5. Three members of healthcare staff attended the cell and agreed that it was too late to start cardiopulmonary resuscitation (CPR).

6. At around 9.30am, paramedics arrived and confirmed that Mr Munoz had died.

## Findings

7. Some positive action was taken to support Mr Munoz through his time in prison. The ACCT procedures were generally well managed, and staff identified quickly that he was under threat from other prisoners. A prison chaplain provided particularly commendable support.

8. However, there were some missed opportunities to provide additional support to Mr Munoz. His isolation and management under ACCT procedures meant he should have been recognised as a priority prisoner for key work, but he was not allocated a key worker in line with expectations. While staff recognised that he was under threat, there is little evidence that any action was taken to identify the perpetrators.

# The Investigation Process

9. We were notified of Mr Munoz's death on 16 May 2022.

10. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Munoz's prison and medical records.

12. The investigator interviewed 11 members of staff at HMP Manchester in December 2022 and January 2023.

13. NHS England commissioned a clinical reviewer to review Mr Munoz's clinical care at the prison. The majority of interviews were conducted jointly by the investigator and clinical reviewer.

14. We informed HM Coroner for Manchester City of the investigation. We suspended our investigation between 16 June and 29 November 2022 while awaiting the post-mortem and toxicology reports for Mr Munoz. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Munoz's family to explain the investigation and to ask if they had any matters they wanted us to consider. They requested a copy of our report but did not have any specific questions.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and this report has been amended accordingly.

17. Mr Munoz's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.



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# Background Information

## HMP Manchester

18. HMP Manchester is a high security prison which accepts category A and B prisoners. The prison holds up to 744 men in nine residential units, a segregation unit, specialist intervention unit and a healthcare unit. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care.

## HM Inspectorate of Prisons

19. The most recent full inspection of HMP Manchester was in September 2021. Inspectors reported that 25% of prisoners said they felt unsafe at the time of the inspection and results for those with mental health problems or other disabilities were significantly more negative than other prisoners.

20. Inspectors reported that the mental health team was responsive to demand, promptly assessing patients and prioritising support. They noted that a dual diagnosis pathway for patients with both mental health and substance misuse needs was being used effectively.

## Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 28 February 2022, the IMB reported that the prison had a steady decrease of self-harm in the early part of 2021, which mirrored trends shown across the prison estate throughout the COVID-19 pandemic.

22. Self-harm rose sharply in September 2021, when COVID-19 restrictions were lifted and has remained higher since then. This rise coincided with prisoners being allowed to return to mixing in larger groups, visits recommencing and increased Covid-related staff shortages. Initial analysis indicated that the stability of having regular staff working with the prisoners and a predictable regime provided the continuous support needed by prisoners who were struggling. To reduce this risk of self-harm, the Head of Residence aimed to ensure that all prisoners being monitored under suicide and self-harm prevention measures (ACCT) were allocated a key worker to provide them with that stability of support on top of the usual ACCT processes.

## Previous deaths at HMP Manchester

23. Mr Munoz was the 20th prisoner to die at Manchester since May 2019. Eleven of the previous deaths were from natural causes, three were drug-related, three were self-inflicted and two were unascertained. Since Mr Munoz’s death, three more prisoners have taken their own lives at Manchester.

24. Our report into the self-inflicted death of a prisoner in February 2022 identified that he was the victim of an assault that was not properly investigated.

## Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

26. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key worker scheme

27. The key worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversations which each of their allocated prisoners.

28. The key worker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, the Prison Service used an Exceptional Delivery Model until May 2022. This involved weekly conversations with prisoners identified as vulnerable due to their risks or circumstances.

29. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan, which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

# Key Events

30. On 11 March 2022, Mr Alex Verdu Munoz was charged with murder and remanded to HMP Dovegate (a Category B prison). According to his records, Mr Munoz had been in the United Kingdom for around six weeks prior to committing his offence. He reported having no criminal record in his home country of Argentina. A prison chaplain who knew Mr Munoz well told us that he spoke good English and was able to hold reflective, theological conversations in English.

31. After committing the alleged offence, Mr Munoz sustained serious leg injuries in a car accident while being chased by police. He was prescribed codeine for pain relief but, following a risk assessment, was not allowed to keep his medication in possession in prison. He attended regular GP and nurse appointments while in prison, to assess and treat his injuries.

32. At Mr Munoz's initial healthcare screening, the nurse submitted an automatic referral to the mental health team. Prison staff began monitoring him under suicide and self-harm prevention procedures (ACCT) due to the nature of alleged offence. Observations were set at a minimum of three per hour, with three quality conversations per day.

33. On 14 March, staff transferred Mr Munoz from the induction unit to the segregation unit pending a transfer to a Category A (high security) prison. Due to being in segregation, staff increased Mr Munoz's observations to a minimum of five per hour.

34. The next day, Mr Munoz attended an initial ACCT assessment and said that he had never spoken to a mental health professional or counsellor before. He reported having no emotions and said he could not laugh or cry properly. He said that the COVID-19 lockdown had exacerbated his feelings of hopelessness. Mr Munoz refused to answer questions about any previous trauma he may have experienced and said he had no thoughts of suicide or self-harm.

## HMP Manchester

35. On 17 March, Mr Munoz was transferred to HMP Manchester while still under ACCT monitoring. The reception nurse completed an initial health screening. She recorded that Mr Munoz engaged well. She raised no immediate mental health concerns. She added that Mr Munoz should be allocated a "low level" cell because he was using crutches and had restricted mobility.

36. A mental health nurse completed Mr Munoz's mental health triage assessment. Mr Munoz told her that he had no thoughts of suicide and self-harm and was coping well with being in prison. She referred him to the mental health team for a full assessment due to the nature of his offence.

37. On 18 March, a mental health nurse completed Mr Munoz's full mental health assessment. She recorded that she had no concerns about Mr Munoz's mental health and noted that his ACCT remained in place as a supportive measure. An ACCT review took place later that day, which reduced Mr Munoz's observations to five nightly observations and four quality conversations per day.

38. Mr Munoz was recovering from an open fracture to his shin bone and had contracted methicillin-resistant staphylococcus aureus (MRSA - a type of bacteria that is resistant to several widely used antibiotics) while in hospital. Therefore, staff decided that Mr Munoz was not fit for work or cell sharing. They allocated him a cell on E Wing (a standard residential unit).

39. On 21 March, an officer recorded that Mr Munoz was “quite clearly a target and under threat” on E Wing due to his offence, which had received national media coverage. The officer noted that a move to the prison healthcare centre was necessary to ensure Mr Munoz was supported while recovering from his injuries. The move was not possible at the time due to lack of space. He noted that officers were trying to facilitate a separate regime for Mr Munoz in the meantime, to separate him from other prisoners. There was no evidence of any further action to identify who Mr Munoz might be at risk from, or to address any negative behaviour directed at him.

40. On 23 March, at an ACCT case review, Mr Munoz reported that he felt “fine” and said he had started reading the Bible. However, he said he had been threatened by prisoners on the wing due to his offence. Staff had now arranged a separate regime for Mr Munoz and assured him that he would be moved to the healthcare centre as soon as a space became available. Staff decided to keep the ACCT open with the same level of observations.

41. Staff opened a self-isolation plan to record Mr Munoz’s daily regime. The next ACCT review meeting took place on 30 March. Mr Munoz said that he was concerned he may become addicted to his codeine medication. In response, staff agreed to put measures in place to support him with advice and support when this medication was eventually reduced. Mr Munoz reported that his mental health was “fine”, and he had no intention of harming himself. Staff decided to keep the ACCT open with the same level of observations.

42. On 13 April, prison staff held Mr Munoz’s next ACCT case review. They recorded that Mr Munoz was making progress but that the ACCT should be kept open due to his upcoming trial and lack of family support in the UK. Observations were reduced to three quality conversations per day and four observations at night.

## Move to Inpatients’ unit

43. On 14 April, Mr Munoz was transferred to the healthcare inpatient unit when a space became available. Staff closed Mr Munoz’s self-isolation plan, however they continued to monitor him under ACCT procedures.

44. On 27 April, Mr Munoz’s first ACCT review on the healthcare unit took place, attended by a Supervising Officer (SO) (the ACCT case coordinator), a nurse, a prison chaplain and Mr Munoz. Mr Munoz told the group that he had been threatened by prisoners on the healthcare unit due to his offence. With Mr Munoz’s consent, the SO agreed to facilitate a separate regime where Mr Munoz would be kept apart from other prisoners. He warned Mr Munoz that this could restrict his time out of his cell, but Mr Munoz said he was okay with this. He recorded in the ACCT document that staff would observe prisoners closely to see if they could find out who was making threats towards Mr Munoz. Mr Munoz told the group that he had no thoughts of suicide and self-harm and would speak to staff if this changed.

45. The chaplain confirmed that Mr Munoz was working with chaplaincy and completing an education course, which he was positive about. Mr Munoz told the group that he was writing a novel, watching television, and exercising in his cell to distract himself. She said she would continue to support Mr Munoz through regular contact. The group agreed that Mr Munoz's ACCT should remain open with the observations set at three daily observations and conversations and four observations during the night.

46. On 5 May, Mr Munoz's next ACCT review meeting took place. The review was attended by the new ACCT case coordinator, the chaplain and Mr Munoz. Mr Munoz told the group that prisoners were shouting names during the night, but he did not know if they were talking about him. He said he was content in his own company. Mr Munoz said he was due to see his solicitor the next day to find out more about his upcoming court appearances. He said he had not been in contact with his family in Argentina, but that his solicitor kept him updated about them. He said he saw the chaplain regularly, was writing a lot and taking the necessary steps to get involved in education classes. With a court appearance looming and no family contact, the group agreed to keep the ACCT open with the same level of observations. They set the next case review for 19 May.

47. On 13 May, Mr Munoz attended court as part of the ongoing legal proceedings relating to his murder charge.

48. On 14 May, a nurse completed a welfare assessment on Mr Munoz as a precautionary measure following his court appearance. Mr Munoz said that he was fine. She did not raise any concerns about Mr Munoz and found him to be pleasant and polite during the conversation. Mr Munoz said that he did not have any thoughts of suicide or self-harm and she noted that no other concerns had been raised by officers on his landing. Mr Munoz was due to attend court on 16 May, and there was a documented plan for a mental health nurse to complete a welfare check on his return. For the rest of the day, officers continued their ACCT checks on Mr Munoz as normal and raised no concerns.

49. At around 9.30pm, an officer completed the first of four overnight ACCT checks for Mr Munoz. In interview, he told us that Mr Munoz was sitting up watching television. He had a brief conversation with Mr Munoz and raised no concerns.

50. At around 11.30pm, the officer completed the second ACCT check on Mr Munoz and recorded that he was asleep in bed, noting signs of movement. He raised no concerns.

51. The officer completed two further ACCT checks at around 3.00am and 5.00am. On both occasions he saw that Mr Munoz was asleep and noted signs of movement. He raised no concerns.

## Emergency response

52. CCTV shows that, at 7.10am on 15 May, an officer completed the first of the daily ACCT observations on Mr Munoz. He told us that Mr Munoz was lying in bed with the television on. He said that Mr Munoz did not acknowledge him, however, he noted that his chest was moving up and down. He raised no concerns and continued with his ACCT checks.

53. At around 8.30am, an officer started collecting outstanding canteen sheets from prisoners on the healthcare unit, assisted by a prisoner. At around 9.15am, the prisoner reached Mr Munoz's cell and shouted for the officer to join him. The officer ran to the cell and looked through the observation panel in Mr Munoz's cell door. He was lying on the cell floor with a ligature around his neck, attached to the bedframe. The officer immediately radioed a medical emergency code blue, which triggered the control room to telephone an ambulance. He entered the cell and cut the ligature. He told us that Mr Munoz showed no signs of life.

54. Another prisoner on the healthcare unit quickly approached a healthcare assistant, a nurse, the Deputy Inpatient Manager and a social care worker, who were nearby at the treatment room. Within seconds, the three members of healthcare staff attended the cell and were told by the officer that it was too late to start cardiopulmonary resuscitation (CPR), which the other staff agreed with. The nurse checked for a pulse but could not find one. She confirmed that there was clear evidence of rigor mortis in Mr Munoz's body.

55. At around 9.30am, paramedics arrived and quickly confirmed that Mr Munoz had died.

56. Police attending Mr Munoz's cell found a note written in Spanish. The note was addressed to Mr Munoz's family and indicated that his intention was to take his life.

## Contact with Mr Munoz's family

57. Manchester nominated a prison family liaison officer (FLO). After initially struggling to find up-to-date contact details for Mr Munoz's family in Argentina (he had not telephoned his family from prison), she identified their telephone number. She broke the news of Mr Munoz's death to his sister at around 9.00am on 16 May 2022.

58. Manchester contributed to the cost of Mr Munoz's funeral in line with national HMPPS policy.

## Support for prisoners and staff

59. After Mr Munoz's death, the an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

60. The prison posted notices informing other prisoners of Mr Munoz's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Munoz's death. Staff spoke to the prisoner who found Mr Munoz hanging in his cell and offered him support, which he declined. However, the prisoner asked for an inter-prison telephone call with a family member which staff facilitated for him.

## Post-mortem report

61. The post-mortem report concluded that the cause of Mr Munoz's death was hanging. The toxicology examination found nothing significant in Mr Munoz's system.

# Findings

## Management of risk of suicide and self-harm

62. Prison service Instruction (PSI) 64/2011 'Managing Prisoner Safety in Custody' requires that staff who have contact with prisoners are aware of the risk factors and triggers that might increase suicide and self-harm, so that they can take relevant action. Risk factors include violent offences and first entry into prison. The PSI requires staff to start ACCT procedures where they identify an increased risk of harm.

63. Staff appropriately began ACCT procedures when Mr Munoz first arrived in prison charged with murder and continued monitoring him under ACCT procedures when he arrived at Manchester. He was an Argentinian national who had spent only a matter of weeks in the United Kingdom before his remand, so there was no documented health history available, and Mr Munoz did not disclose any history of or thoughts of suicide or self-harm. Case reviews were multidisciplinary and involved a range of staff who knew Mr Munoz and could make good quality contributions.

64. At his final ACCT case review on 5 May 2022, Mr Munoz appeared well, was making future plans and was positive about his regular contact with the prison chaplain.

65. The chaplain told us that she suspected Mr Munoz may have felt isolated due to being on a separate regime. Striking a balance between Mr Munoz's safety (due to the alleged threats he was receiving) and managing the impact of isolation on his wellbeing was difficult. Prison staff made consistent efforts to respond to Mr Munoz's specific needs in challenging circumstances by moving him to the healthcare inpatient unit and implementing a separate regime while monitoring his wellbeing through the ACCT process. After his initial concerns about threats from other prisoners, Mr Munoz appeared to settle on the healthcare unit. He told staff that he was content in his own company and did not exhibit any obvious signs that he was in crisis.

66. Prison staff rightly completed welfare checks following Mr Munoz's court appearances, which might have increased his risk of harm to himself. A nurse had no concerns about his wellbeing and told us that he appeared "quite unremarkable".

67. We do not consider that prison or healthcare staff missed any opportunities to identify an imminent risk of harm.

### Good practice

68. Despite Mr Munoz repeatedly and consistently denying that he had any thoughts of self-harm, prison staff took account of wider known risk factors and kept the ACCT procedures open. This is a good example of staff recognising that what a prisoner says is not a reliable indicator of their likelihood of self-harm.

## Clinical care

69. The clinical reviewer concluded that the clinical care provided to Mr Munoz at Manchester was equivalent to that which he could have expected to receive in the community. She makes recommendations on issues that did not impact on Mr Munoz's death, for the Head of Healthcare to address.

## Good practice

70. We were impressed by the dedication shown by the prison chaplain. She provided excellent support to Mr Munoz throughout his time at Manchester and displayed genuine concern for his safety and wellbeing. She took time to build a meaningful relationship with Mr Munoz through frequent contact. We commend her for her efforts.

## Governor to note

### *Key work*

68. One of the main aims of the Key Worker Scheme is to improve prisoner safety through meaningful contact with a consistent member of staff. The scheme usually requires 45 minutes of key work per prisoner per week, delivered by a named officer. Despite being a prisoner remanded for murder under ACCT monitoring, Mr Munoz was not allocated a key worker at Manchester.

69. The Exceptional Delivery Model in place for key work during the Covid-19 pandemic was stood down in March 2022 and key work was expected to be rolled out again in full from April 2022. The IMB Annual Report for the year to February 2022 notes that the Head of Residence at Manchester was aiming to ensure that all prisoners being monitored under ACCT procedures were allocated a key worker to provide them with further stability on top of the usual ACCT processes.

70. Mr Munoz spent two months at Manchester, during which time he did not receive any key work. In interview, an operational manager at Manchester told us that Mr Munoz should have been allocated a key worker when he came on to the healthcare inpatient unit. He said that failure to do this had been an oversight.

71. Another operational manager told us that key worker delivery has fluctuated since the pandemic but has never been above 30 per cent. She identified various reasons for this, including staff sickness, priority escorts for Category A prisoners and provision of staff on detached duty. She identified that Manchester has reviewed prisoner groups who are priorities for key work and that this now includes those who are isolating (which would have included Mr Munoz). She told us that Manchester now allocates staff on restricted duties (such as those with health conditions that might prevent them from completing some wider duties) to key work to achieve better completion.

72. Key work might have provided Mr Munoz with an opportunity to develop a meaningful relationship with another named member of staff and to share his concerns. We note the chaplain was able to develop a relationship with Mr Munoz,

which he reflected on positively. However, it is important that Manchester is supported to roll out key work in full, in line with national HMPPS policy.

### *Threats to Mr Munoz*

73. Mr Munoz isolated himself from other prisoners as a result of threats he said he had received. Staff recognised that he was under threat, with one officer recording that Mr Munoz was “quite clearly a target”.

74. Manchester has a local violence reduction policy which states that they will identify and support those who are victims of violence. This should include those under threat of violence. The policy states that all incidents should be reported correctly, with investigations and actions undertaken.

75. Prison staff recognised that Mr Munoz needed additional support when he was under threat and some positive action was taken. While Mr Munoz did not name any of the apparent perpetrators of threats against him, there is little evidence that any investigation was undertaken to identify them or to take action to address the issue. Given that it was clear to staff that his fears, particularly when he lived on E Wing, had some substance, this was a significant omission.

## Inquest

76. The inquest into Mr Munoz’s death finished on 13 May 2026 and concluded that he died as a result of suicide.

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